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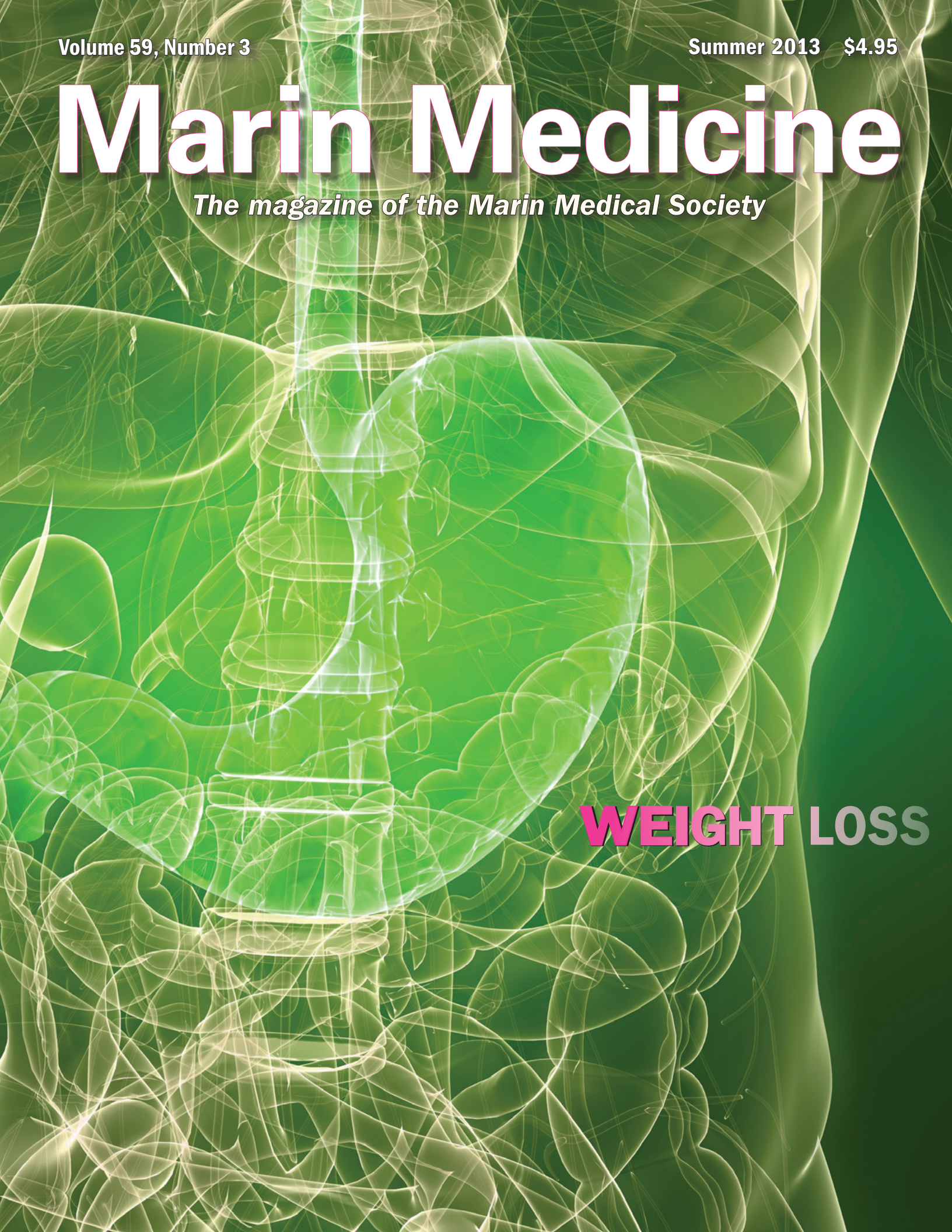

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Obesity: A Strategic Approach

Gail Altschuler, MD

Obesity is a complex, multifaceted medical condition defined as excess body fat. It is chronic and progressive, with an adverse effect on patient health. Early medical intervention offers our most successful approach, yet doctors are often reluctant to discuss weight loss with their patients. Doctors are busy and may not fully understand the positive difference weight loss can make in a patient's health. In addition, they are often concerned about making their patients uncomfortable by discussing their weight—yet it must be just as frustrating to add medications for hypertension, diabetes, hyperlipidemia or osteoarthritis while knowing that weight loss can treat the causes rather than the symptoms of these conditions. Weight reductions of as little as 10% can make a significant difference.

Only 45% of obese patients have been told to lose weight by a health professional, but those who have been told are almost four times more likely to try losing weight.[1] Patients want their physicians to give dietary advice, help them set realistic weight-loss goals and offer exercise recommendations. Good ways to start conversations about weight loss include:

- Would it be all right if we discussed your weight?

Dr. Altschuler, a bariatric physician, is medical director of The Altschuler Center for Weight Loss & Wellness in Novato and Greenbrae.

- Are you concerned about your weight?
- I'm concerned about your weight because I believe it's causing health problems.

Patients prefer words and phrases such as *weight, unhealthy weight, excess weight* and *unhealthy BMI* to describe their condition. On the other hand, they are offended by *obese, fat* and *large size.*

Preventing obesity is far easier than reversing it. The best time to intervene is when a patient is 10 or 20 pounds overweight, when small adjustments can make a big difference. These adjustments can include environmental controls, substitutions, planning and support.

Environmental controls and substitutions can make a huge difference. Patients have been conditioned to eat sugar, fat and salt, and they regularly come across foods with high levels of these elements. Environmental control requires eliminating these tempting or "trigger" foods at home and at work, identifying good-tasting healthy foods, and keeping these healthy foods readily available. One way to keep healthy foods available is to prepare a pot of something tasty on the weekend for lunches or a quick meal during the week. Another substitution option is to keep high-protein, low-calorie snacks handy at all times.

For planning, patients should take time to consider what they will need throughout the day and how they will handle challenging situations as they arise. You can support these patients by reminding them that they deserve to have safe work and home environments that meet their needs. Such support extends to your own office, where you can supply seats, gowns and blood-pressure cuffs that are large enough for overweight patients. You can also regularly measure waist circumference and BMI, and make them part of routine vital signs. In addition, you can offer handouts with diet and exercise recommendations, and arrange for monthly visits to support and encourage continued progress.

When a patient has significant weight gain and/or medical or social problems that are impacted by their weight, and they have not responded to your initial efforts, there are multiple resources available. Physician-supervised weight-loss programs, for example, can be the next step in the treatment continuum. The National Weight Control Registry has found that 55% of people who successfully lose weight do so with the help of a program.[2]

A bariatrician (obesity specialist) can provide the support, accountability and attention needed to achieve sustained weight loss. Bariatricians have extensive training in factors causing and contributing to obesity, along with the experience to address these complex issues. A successful bariatric program sees weight loss as the beginning of a healthy lifestyle, not as an end in and of itself.

At The Altschuler Center, where I serve as medical director, we view losing weight as a three-stage process: weight loss, transition and maintenance. During the initial consultation, we explore the patient's needs and expectations and recommend a program. We also request appropriate lab and EKG; we're looking for medications or medical conditions that might impact weight. Throughout the appointment, we answer questions, set expectations and, most important, establish a commitment. This initial visit sets the stage for successful, long-term weight loss. Generally, our patients leave with a clear picture of how they can achieve their weight-loss goals.

For the weight-loss phase of our program, I find that a low-calorie, low-carbohydrate approach works for most patients. This approach promotes burning fat and building muscle, and it controls hunger. Once a patient's usual pattern is interrupted and weight-loss momentum is achieved, I address the emotional and cultural challenges that often lead to weight gain.

During weekly visits, patients report their accomplishments, challenges and any medical issues they've experienced. I discuss progress and build skills needed to maintain healthy weight. Results from the week are reviewed, adjustments made, challenges discussed. Plans are then laid for the following week.

One approach I frequently use is called partial meal replacement. Patients are encouraged to eat two healthy meals a day and use protein replacements for between-meal snacks. Protein meal replacements provide a convenient, portion-controlled, nutritionally sound replacement for tempting high-calorie foods. Using these replacements allows patients to keep the calories down while maintaining metabolic balance and controlling hunger. An average weekly weight loss is 2–3 pounds, which is healthy and sustainable. Healthy meals, during this initial weight-loss phase, can include restaurant and family meals when an appropriate approach is included.

Medications can help control appetite when needed, either when a patient is getting started or to help with a plateau. Obesity is a medical condition with serious health consequences and should be treated with all the tools available to ensure the best result.

Transition is an oft-overlooked but critical stage. Too often, people conclude that once they have lost weight they are home free.

For the transition phase of our program, patients continue enjoying healthy meals with family and friends and the flexibility to eat in restaurants while simultaneously building the skills to cook, shop and prepare their meals. They are expanding their skills, practicing new strategies and beginning to master the skills needed for long-term success. These skills are the foundation for a healthy life.

During this phase, I work to transform the patient's relationship to food, their weight and their life. My goal is to challenge and change. It is naive to imagine that someone losing weight can return to previous ways of thinking about food and exercise.

For the maintenance phase, I tell patients it takes as much work to keep weight off as it does to lose it. It's a different set of skills. Years of repetition and practice are required for these new skills to become automatic. I teach the skills and strategies needed to manage their weight no matter what the outside circumstances. I challenge the notion that a diet is something they do for a while and put up on a shelf when it's inconvenient.

Maintenance is discussed beginning with the first visit. Many people view dieting as a temporary inconvenience, and up to 85% who lose a significant amount of weight are likely to gain that weight back. Successful patients wake up each morning and ask themselves, "How am I going to beat those statistics?" According to the National Weight Control Registry, people who lose weight and keep it off have the following characteristics:

- 78% eat breakfast every day.
- 75% weigh themselves at least once a week.
- 62% watch less than 10 hours of TV per week.
- 90% exercise, on average, about one hour per day.

One successful maintenance strategy is self-monitoring, such as wearing fitted clothing and weighing at least once a week; I advise three or more weighings per week. Managing weight without weighing oneself is like sailing across the ocean without a compass. It's the information that lets us know if what we're doing is working.

Another successful strategy is the notion that "Five pounds is an emergency." Patients need to take immediate action if they regain five pounds. Managing weight within this narrow range makes maintenance easier. The body is designed to keep us from wasting away, and the forces to eat and store can be very powerful.

Bariatric surgery is recommended for people with a BMI of 40 or greater and for people with a BMI of 35 with comorbid conditions. Recently recommendations have been adjusted to include lap-band surgery for people with BMI of 30 or greater and comorbid conditions. Bear in mind that men with a BMI greater than 40, ages 25–34, have a 12-fold increase in overall mortality. Furthermore, obesity is one of the only modifiable risk factors for cardiovascular disease—the No. 1 killer of women.

Bariatric surgery does work. It can resolve many illnesses and return a person to good health in a relatively short time. Not everyone is willing or interested in surgery, however. My job is to educate patients in the range of

available treatments, enabling them to choose the approach best suited to their needs. In general, when someone has had multiple failed attempts at weight loss and their health and quality of life are markedly diminished by their weight, I encourage them to attend a support group and go for a consultation.

After bariatric surgery, patients need significant follow-up care. Surgical patients initially experience rapid weight loss, but they must use the first one or two years to establish healthy routines. If not, they risk regaining the lost weight. I also screen for depression, addiction and abuse in these patients, which can often trigger overeating. Surgery cannot treat the real needs in these cases.

Conventional weight-loss skills apply to surgery patients as well, including sleep and stress management, dietary interventions, low-calorie diets, physical activity, eating at home, psychological interventions when needed, and anti-obesity medications. They also need to be checked for nutritional deficiencies, per post-surgery protocols.

In conclusion, physicians should be the first responders to the American obesity epidemic. Obesity affects over 30% of patients seen, and there are direct connections between illness and overweight. Understanding obesity's impact and the benefits of intervention is a beginning. Fortunately, this epidemic can be addressed through early recognition and a systematic approach. Not every patient needs physician oversight, but in cases where oversight is indicated, it can mean the difference between success and failure. ◇

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Going Soda Free in Marin to Combat Obesity

Matthew Willis, MD, MPH

Nearly one in three children in Marin, and nearly one in two adults, is overweight or obese. Local healthcare providers see the impact of obesity every day, across the age spectrum: an 18-month-old whose weight continues to climb above the 95th percentile; a 10-year-old obese boy who is bullied in school and depressed; a 16-year-old girl with hypertension and high cholesterol; an overweight young woman with gestational diabetes; a 50-year-old obese woman with debilitating knee arthritis; a 65-year-old man with congestive heart failure and worsening renal function. These routine presentations are largely preventable.

Obesity is a model condition for partnership between public health and clinical medicine because it is epidemic, preventable and curable. As one important step in combating obesity, public health practitioners in Marin County are taking steps to limit the harmful consumption of sugar-sweetened beverages. According to the CDC, consumption of these beverages (including soda, sweetened juices, and sports and energy drinks) is a major driver of the obesity epidemic. Over the past decade, per capita intake of calories from sugar-sweetened beverages has increased by nearly 30% nationally, partly due to marketing strategies targeted to children and adolescents. For each extra can or glass of sugared beverage consumed per day, the likelihood of a child's becoming obese increases by 60%.

Dr. Willis is the Public Health Officer for Marin County.

This summer, the Department of Health and Human Services, supported by a resolution from the county Board of Supervisors, will be partnering with LIFT-Levantate and the Marin City Community Services District to promote Soda Free Summer. This initiative includes education on how to read labels to determine the amount of sugar and how to make healthy refreshing water drinks with the addition of fresh fruit and herbs. The Marin County Nutrition Wellness Program (NWP) will host trainings and events on how to Rethink Your Drink throughout the summer at a variety of community based organizations and summer programs for youth.

In addition, the NWP will be working with community leaders in the Canal District and Marin City to help reduce access to sugar-sweetened beverages in these neighborhoods. Childhood obesity rates are higher in these communities than in other parts of Marin. These high rates increase the risk of diabetes and other strong cardiovascular risk factors, perpetuating the disparities we are already seeing in life expectancy in Marin. The current gap in life expectancy between the wealthiest and poorest neighborhoods in Marin is 17 years.

Another important public health approach to obesity borrows from the success of tobacco control. Tobacco taxes contributed to a significant reduction in smoking rates in this country. State Senator Bill Monning (D-Carmel) has introduced Senate Bill 622 to tax a penny per ounce of sugar-sweetened beverages and to use the money gained from those taxes to fund obesity prevention and treatment programs. California Health Officers and Marin HHS support this tax on sugar-sweetened beverages as a means to reduce consumption and for the price of soda to reflect its true cost to society.

A study published by Columbia and UCSF researchers last year suggested that a penny-per-ounce tax would reduce consumption of sugary drinks by 15% and showed how corresponding reductions in obesity and diabetes rates could save the healthcare system $17 billion.[1] In another parallel with the tobacco-control debate, the American Beverage Association spent about $3.5 million in lobbying efforts and advertising to defeat soda tax initiatives in Richmond and El Monte last year. Soda taxes could fund a massive public health education campaign to guide healthy decisions.

The Soda Free Summer and the pro-

posed soda tax are small but important steps towards changing norms around consumption of sugar-sweetened beverages. The solution to the growing burden of obesity must be multifaceted and long-term, and it will require commitments from healthcare providers, public health advocates, and the communities and individuals they serve. Last year, soda was removed from all vending machines in Marin County HHS buildings. Clinics or hospitals that still sell soda in vending machines are invited to join in the spirit of Soda Free Summer. Removing soda from vending machines demonstrates an understanding of the evidence in combating obesity, and it reminds patients of our role as stewards of their health. ◇

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Bariatric Surgery Update

Gregg Jossart, MD, FACS

In 1995, surgeon Walter Pories published an article in the *Annals of Surgery* titled, "Who would have thought it? An operation proves to be the most effective therapy for adult-onset diabetes mellitus." Almost two decades later, the United States is in the middle of an obesity-related diabetes epidemic. More than 100 million Americans have diabetes or prediabetes, and more than 70 million are obese.

Two-thirds of adult-onset diabetes is directly associated with obesity. Obesity is also associated with more than 40 other medical problems, such as heart disease, cancer, sleep apnea and orthopedic issues. All of these problems, including the obesity itself, tend to worsen with time. Although the problems can be treated to some extent with medications, CPAP devices and physical therapy, the core problem that remains is the obesity. Diet and exercise are always the best starting point for obesity, but failure does occur, and the obesity persists.

Obesity surgery has the highest cure rate for obesity and its related illnesses, but it has long been viewed as a last resort and thought to be dangerous. That view is changing because of newer, safer procedures and how well diabetes is cured with surgery. In April, the American Association of Clinical Endocrinologists recommended obesity surgery as an earlier treatment option in the obesity disease process. Surgery has the highest cure rate when obesity-related diabetes is in the earliest stage—not when a patient has had diabetes for 10 or more years and is approaching 400 or more pounds in weight.

Dr. Jossart, a bariatric surgeon, has offices in Novato and San Francisco.

In the last 20 years, numerous advances have occurred that make surgical weight reduction an earlier option in the treatment of obesity and diabetes. The main advances are the laparoscopic approach, increased safety and lower-risk procedures. The evolution from open to laparoscopic surgery began in 1994, and now almost all weight-loss surgery is performed laparoscopically. Laparoscopic patients have less pain and fewer complications, and they usually require only one night in the hospital. Both the laparoscopic approach and increased surgeon experience have reduced complication rates to the point that bariatric surgery has been proven to be safer than even gallbladder surgery.

The two methods of surgical weight reduction are restriction and malabsorption. Restriction reduces oral calorie intake by decreasing the size of the stomach. All current bariatric surgical procedures include some degree of restriction. In the gastric band procedure (Figure 1), a silastic (silicone rubber) band that acts to restrict food is placed around the top of the stomach. In a sleeve gastrectomy (Figure 2), staples are used to reduce the size of the stomach.

Malabsorption is a more complex technique that involves both restriction of the stomach and rerouting of the small intestine. In the gastric bypass (Figure 3), the stomach is divided to create a small pouch that is connected to the small intestine. In the duodenal switch (Figure 4), the stomach is restricted as in a sleeve gastrectomy and a large amount of intestine is rerouted so that only a short segment carries food and the bypassed segment carries the digestive juices.

All four of these procedures achieve weight loss and diabetes resolution, and all are approved by insurance companies. Malabsorption can achieve a more durable weight loss and perhaps a better cure for diabetes, but it may also yield more long-term nutritional deficiencies and other complications related to the intestinal bypass.

The sleeve gastrectomy (or gastric sleeve) reduces stomach volume without changing the intestines or using a foreign body (the gastric band). This type of reduction allows for a balance between portion size and range of food choices, with fewer side effects. The proportion of sleeve gastrectomies in American bariatric surgeries has increased from 2% in 2008 to 44% in 2012; insurance companies started approving sleeve gastrectomies in 2010.

Sleeve gastrectomies are particularly appealing to patients because they avoid all the potential problems of the more complex bypass operations as well as the foreign-body problems of gastric banding. The weight-loss and diabetes cure rates for sleeve gastrectomy are similar to the bypass operations, with a much lower risk profile. Historically, surgeons were slow to offer sleeve gastrectomy to patients as it involves removing most of the stomach and is not

reversible. They also thought weight loss would be inadequate or weight gain would occur because the operation only reduced stomach volume.

Results over the last five years, however, have proven that sleeve gastrectomy yields durable weight loss and diabetes improvement.[1] There is also some proof that removing the volume part of the stomach (greater curvature) also removes most of the cells that produce ghrelin, the hunger hormone.[2] This phenomenon may explain why sleeve gastrectomy has better than expected weight-loss results. Overweight diabetic patients who choose sleeve gastrectomy are delighted with the reduction in appetite; the early and lasting fullness after small portions of food; and the rapid improvement in their diabetes, to the point where they no longer need insulin or even oral medications.

Critics of sleeve gastrectomy claim it has not been studied well enough yet and that without an intestinal bypass the results will be inadequate. Medicare and most insurance companies, however, have decided that sleeve gastrectomy is effective. The lack of an intestinal bypass may actually be what makes sleeve gastrectomy so appealing to patients. Despite all these benefits, however, both physicians and patients need to realize that sleeve gastrectomy is most effective and safe at lower levels of obesity (BMI <55) and within the first few years of a diabetes diagnosis. ◇

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Figure 1.
Gastric band

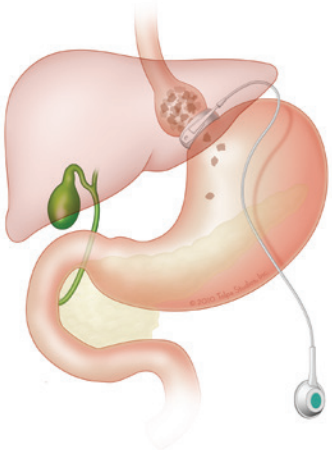


Figure 2.
Sleeve gastrectomy

Figure 3.
Gastric bypass

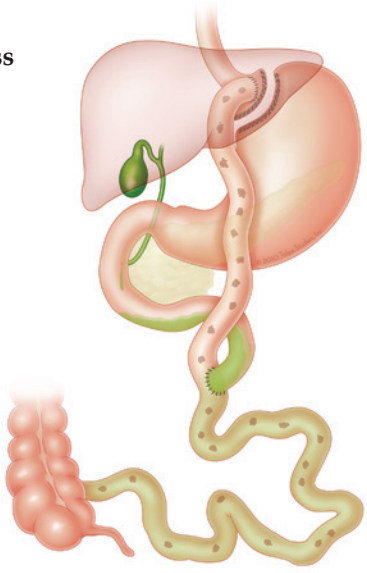
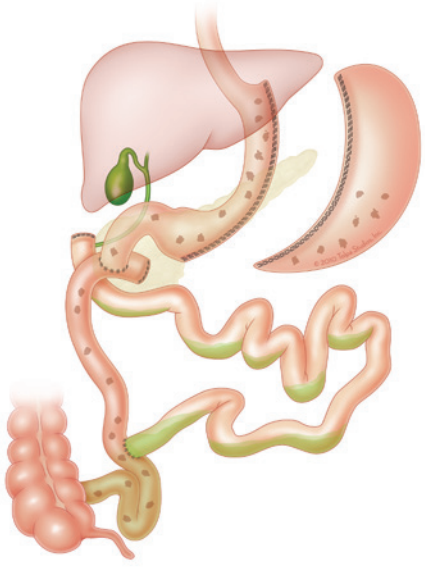


Figure 4.
Duodenal switch



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Seven Exciting Topics in Bariatric Medicine

Sean Bourke, MD

After 14 years in emergency medicine, I headed down an uncharted path. Sick of treating the symptoms of overweight and obesity, I wanted to fight the cause. With a buddy from Stanford Residency, Dr. Conrad Lai, I founded JumpstartMD to combat the biggest health care crises of the 21st century: adiposity and its evil twin adiposopathy, or "sick fat." Looking back, I had no idea how gratifying this journey would be, and what a positive impact we would have on people's lives.

I was also surprised to see how misguided the information we'd received in medical school had been on this topic, and how many "luminary" thought leaders would emerge from right here in the San Francisco Bay Area to help lead our field out of the darkness of old thinking and flawed science.

In honor of those luminaries and the marvelous journey that has transpired since we founded JumpstartMD seven years ago, these are the seven topics I find most exciting in bariatric medicine right now:

Dr. Bourke, CEO of JumpstartMD, was previously an emergency physician at Marin General Hospital.

1. The growing recognition that all calories are not created equal.

Scientific evidence and the collective knowledge of bariatric clinicians on the frontlines of care paint an increasingly clear picture: Individuals vary greatly in their level of carbohydrate tolerance. Carbohydrate intake that exceeds an individual's tolerance may cause adiposity, adiposopathy, or both. Thus carbohydrates—not fat—may well represent the greatest metabolic and cardiovascular health risk contributing to obesity.

Increased consumption of carbohydrates over the past 40 years, both in relative total and as a percentage of all calories consumed, has been the major macronutrient change, in lockstep with the rise in obesity and diabetes. Treatment informed by this perspective enables bariatric physicians to tailor diets matched to an individual's level of carbohydrate sensitivity. It also allows patients to wisely embrace behavioral change in line with optimal, individualized dietary guidance.

That path simply won't be the carbohydrate-heavy, low-fat food "pyramid" we all learned in school. As humans cannot consume more than 30–40% of their calories from protein without untoward consequence, the most carbohydrate-sensitive group (such as those with insulin resistance, type 2 diabetes, or metabolic syndrome) cannot consume a diet that is low in both carbohydrate and fat. For that carbohydrate-intolerant group (and, to varied degrees, the majority of the two-thirds of Americans who are overweight or obese), it is increasingly clear that a well-formulated, low-carbohydrate diet complemented by a good mix of fats is healthier. Additionally, that mix of fats should focus on consumption of heart-healthy monounsaturated fats such as those in avocado, nuts, olive and canola oil; temper fears of cardiovascular risk-neutral saturated fats; ensure adequate intake of omega 3s via fish or good-quality supplements; and minimize intake of industrialized oils (like corn and soy oil).

2. The potential use of two new and potentially influential laboratory assays to assess health risk, monitor efficacy of treatment, and educate and motivate individual patients.

The first assay mentioned, which I am not yet at liberty to discuss, is currently under development and going through academic validation. It promises to accurately predict individual carbohydrate tolerance at the point of care.

The second—lipid fractionation using Ion Mobility testing (the only assay that directly measures low-density lipoprotein particle size)—can more accurately assess metabolic and car-

diovascular health risk and pre- and post-weight-loss intervention efficacy of treatment.

Measuring LDL particle size is beneficial because it is carbohydrates, particularly white flours and sugars (again, not fat), that shape LDL particles into the various medium, small and very small sizes that disproportionately drive cardiovascular risk. Further, smaller LDL particles flag an early proclivity to metabolic syndrome even prior to actual rises in insulin. Because carbohydrate restriction and weight loss are the principal treatments for metabolic syndrome patients, lipid fractionation can help tailor diets for insulin-resistant, higher-risk patients. Additionally, measuring lipid fractionation particles pre- and post-weight-loss intervention in those patients represents new value in terms of helping patients understand why their macronutrient composition matters, and to further motivate optimal dietary compliance.

3. The recent discovery at the Gladstone Institute that the ketone body Beta-hydroxybutyrate served to potently reduce oxidative stress. (See Shimazu T, et al, "Suppression of oxidative stress by beta-hydroxybutyrate, an endogenous histone deacetylase inhibitor," *Science*, Jan. 11, 2013.)

Ketogenic diets have traditionally been maligned by the medical community, largely through a misunderstanding of the differences between the pathologic state of diabetic ketoacidosis (ketone levels 15–25) and the benign state of nutritional ketosis (ketone levels 0.5–5). While further studies are needed, the findings in this study suggest an underlying epigenetic mechanism through which ketogenic diets may serve to prevent oxidative stress and cellular free-radical formation and, thus, might actually slow aging and prevent a variety of diseases, from coronary artery disease to Alzheimer's and beyond.

4. The Vivus Corporation's recent FDA approval for an anorectic medication composed partly of phentermine for long-term use.

Let me clarify: I do not believe that Qsymia, the extended-release topiramate-phentermine combination, offers therapeutic benefit proportionate to its cost in comparison with cheaper, older generic anorectics. However, Vivus's management of the studies needed to assure the FDA that this phentermine extended-release topiramate combination is safe and effective to administer long-term is a positive development.

Bariatrician survey data suggests that the vast majority have been using Schedule III and Schedule IV anorectics off-label safely and effectively long-term for years—but under a chronic and low-level fear of harassment by the Drug Enforcement Administration. Since FDA concerns were not evidence-based, this peeling back of the proverbial onion can only be helpful in further confirmation of their invalidity. The approval of Qsymia for long-term treatment and further studies in progress may therefore pave the way for FDA reevaluation of its regulatory stance around longstanding, safe and effective use of generic anorectics such as phentermine, phendimetrazine and diethylpropion.

Also noteworthy on the medication front: The selective serotonin 2c receptor agonist lorcaserin (Belviq) and a combination bupropion SR and naltrexone SR are both pending FDA approval on the year 2014 horizon.

5. Recognition that, for the vast majority of patients, exercise is a lousy weight-loss tool.

I know this sounds heretical, but the truth will set us all free. While a great wellness tool—think cardiovascular, metabolic, mental and musculoskeletal health—and an important component of weight maintenance, the ill-founded belief that exercise produces weight loss has led too many down a sweaty and demotivating garden path. Living in our "toxic environment" (per Yale Professor Kelly Brownell) rife with ubiquitous and cheap carbohydrate rich foods, you cannot outrun your mouth. Effectively busting that exercise myth is essential.

Why? Because patients need a clear and transparent understanding of what really works to achieve and sustain a healthy weight that's based on science, not catchy marketing or popular magazine advice. The food industry has a great stake in convincing us that our sedentary lifestyles and lack of exercise, rather than the adulterated food supply they're selling us, is the cause of the obesity epidemic; but I'll quote the "consensus statement" from the American Heart Association and the American College of Sports Medicine on this subject: "It is reasonable to assume that persons with relatively high daily energy expenditures would be less likely to gain weight over time, compared with those who have low energy expenditures. So far, data to support this hypothesis are not particularly compelling."

Exercise as a "not particularly compelling" weight-management tool bears out our experience at JumpstartMD with more than 10,000 patients. This should not discourage exercise or the pursuit of improved fitness, but rather spur patients to focus on nutrition first to lose excess weight, and then integrate exercise to promote health and positive body composition changes and to foster long-term success as a complement to weight-loss maintenance.

6. Everyone eats food: The visions of Alice Waters and Michael Pollan.

Alice Waters, the matriarch of the Bay Area good-food movement, has become queen not of haute cuisine but, to use her own words, "simple foods"—foods sourced locally and grown sustainably. She is also founder of the Edible Schoolyard Project and Chez Panisse Foundation, and she has led many back to the pleasures of their kitchens by way of their gardens. Fellow Berkeley resident Michael Pollan has given us embraceable, actionable, pithy phrases everyone can rally around, such as "Eat food. Not too much. Mostly plants"; "Don't eat anything your great-grandmother wouldn't

recognize as food"; "Shop the peripheries of the supermarket and stay out of the middle." His next book on the importance of cooking is due out shortly.

Along with doctors like Steve Phinney, Ronald Krauss and Robert Lustig, leading food and nutrition thinkers like Pollan, Waters and Gary Taubes are creating a dialogue around the new science that makes one thing clear: Nutrition is the lynchpin on which the solution to the obesity crisis must turn. I am grateful for their leadership, the tangible impact this new thinking has had on the Bay Area food movement and on the health of my patients, and the longer-term impact it will have in the evolution of my field.

7. Building the future.

Yes, everyone eats food; yet our modern food supply barely resembles food any longer. We're sold "toxic" nutritional time bombs in pretty, easy-to-consume packaging served up fast, cheap and everywhere you look. At a recent lecture, Dr. Robert Lustig noted that 80% of the 600,000 foods listed in our food supply have added sugar. Average American consumption of sugar has increased from 5 pounds per capita per year in the 18th century to 35 pounds in the 19th century to 156 pounds today. Ouch.

The problem is arguably complex, but the solution is simple: real food. It does not lie in the substitution of one toxic product for another, such as liquid "shakes," chemically preserved "meals," or pointless point systems that allow Twinkies, tuna and taffy interchangeably. All calories are not created equal.

At JumpstartMD, our practice hinges on this belief. Our clinical outcomes have been proven up to three to four times more effective than traditional offerings, and more than 80% of our maintenance patients remain within one pound of their losses because we help them learn healthy habits tailored to their needs and built upon a foundation of whole, fresh, real-food meal strategies that are meant to last a lifetime.

Moving toward "the" solution to this daunting problem is by necessity a collective process that will employ a comprehensive approach that's informed by the seven elements outlined in this piece, and those yet to come. It is this collaborative passion and perpetual search for improvement that I find one of the most exciting elements of bariatric medicine today. ◇

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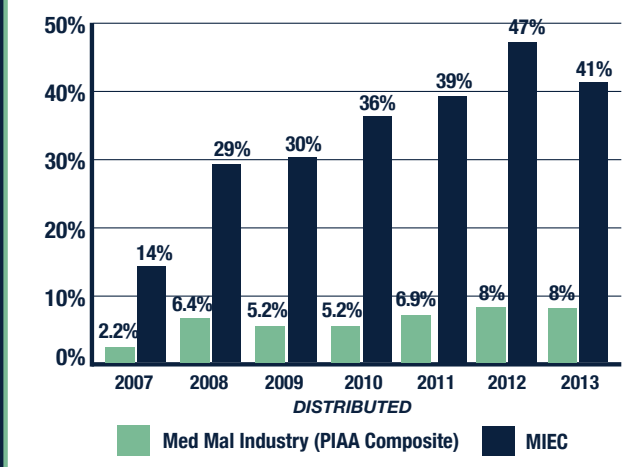

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On the Path to Health

Elaine Christian, MSN, CNM

One quiet, gray morning last December, I took my turn as the on-call midwife at Marin General Hospital. Having completed rounds on the new mothers, and experiencing a lull between the labors and births, I was able to enjoy the Winter 2013 edition of *Marin Medicine*. The edition was dedicated to children's health and included compelling information about the illnesses and lifestyle choices that undermine the well-being of today's children. I learned a great deal from the articles, and they left me wondering if there wasn't something else we could be doing to protect these young patients.

And then I remembered that there *is* something that has been proven to help get infants and children off to a better start: breastfeeding. Not only is breastmilk the ideal nutrition for most infants, including preemies, but it also provides many certain or potential health benefits for young children.[1,2]

There is much scrutiny of the benefits of breastfeeding. The research findings can be particularly difficult to tease apart because it is impossible and unethical to randomize babies to breast versus formula; there are also many confounding variables that influence their health from infancy into adulthood. That being said, giving babies a head start on wellness with the best nutrition, a boost to their immune system, better cognitive development, and the possibility of diminishing their risk for asthma and obesity, is prudent in this era.[3–5]

The Academy of Breastfeeding Medicine is so solidly convinced that babies should be breastfed that they have issued a position statement urging that all physicians, regardless of their discipline, should acquire the current, evidence-based training they need to effectively support breastfeeding mothers and babies. The American Academy of Pediatrics, the American College of Nurse Midwives, the American Academy of Obstetricians and Gynecologists, and many other professional organizations have similar policy statements. They have all responded to the overwhelming body of evidence on the benefits of breastfeeding and to the 1990 World Health Organization/UNICEF pledge to improve infant well-being globally by helping babies have regular and sustained access to breastmilk.

To its credit, Marin General Hospital is able to report that 98% of its babies have access to breastfeeding before discharge.[6] Improved public awareness about the value of breastmilk, the inclusion of this topic at prenatal visits, and our collaborative efforts during and after hospital birth have made a difference of which we can be proud.

Unfortunately, in spite of our remarkable breastfeeding initiation rates, Marin County's rate of any amount of breastfeeding at six months (just 42%) lags behind the average in California, and our rate at one year (only 19%) is dismal (see table). The results are clear. Marin County's babies are getting a good start at breastfeeding, but too many of them are stopping in the early weeks and months after hospital discharge.

Although babies benefit from even the littlest bit of colostrum, the best health outcomes are associated with exclusive breastfeeding—nothing but mother's milk for at least six months. Acknowledging that other benefits of breastfeeding extend well beyond those first six months, the American Academy of Pediatrics (AAP) encourages breastfeeding continuation "for one year or longer, as is mutually desired by mother and infant."[7] This respectful phrasing is appropriate because each mother, child and family has unique reasons and timing for weaning. Like the AAP, the Cochrane Pregnancy and Childbirth Group also found that "the

Breastfeeding Rates

Status	2010 target	U.S.	Calif.	Marin	2020 target
Ever breastfed	75%	75%	88%	98%*	82%
Any BRF until 6 months	50%	43%	56%	42%	61%
Any BRF until 1 year	25%	22%	31%	19%	34%

** Marin General Hospital*

SOURCES: CDC; U.S. Dept. of Health & Human Services; County of Marin

Ms. Christian is a certified nurse midwife with the Prima Medical Group's Midwives of Marin.

available evidence demonstrates no apparent risks in recommending, as a general policy, exclusive breastfeeding for the first six months of life in both developing and developed-country settings."[8]

Responding to the dire needs of children around the globe, the World Health Organization and UNICEF have proclaimed that access to breastmilk for two years or more is beneficial. In the populations I care for at MGH, I have heard reports of breastfeeding for up to 2.5 years, and I know there are toddlers out there who are getting even more.

To get babies off to a good start with breastfeeding, they need access to mother's milk in the first hour after birth. The simple task of bringing babies to mother's chest after birth has been strongly associated with more effective suckling and the long-term goal of sustained nursing.[9,10] In past eras, it was customary to separate the newborn from the mother so that routine admission procedures could be executed. This is no longer the case in hospitals, such as MGH, that favor babies' needs over non-urgent tasks.

MGH Lactation Consultant Julie Moxley notes that the pivotal decision to delay the newborn's first bath has made it easier for babies to carry out their innate desire to nurse. Bonding time was previously interrupted by the first bath and the additional time it took to warm the iatrogenically chilled newborn. When newborns are placed in close, "skin to skin" proximity to their mother's chest, they are better able to regulate their temperature and respirations and to figure out the nuances of their new job of eating and growing—which begins with nuzzling and suckling at the breast.

Breastfeeding studies have also shown that it is best to keep mothers and babies together throughout their hospital stay. During this time families get to know their child, learn the hunger cues and request assistance with any nursing challenges that may develop. We also encourage "nesting time" at home for the first few weeks for the same reason: so that breastfeeding mothers and babies can get in sync.

Although the vast majority of nursing mothers and babies do well with just a little kindness and some help around the house, there are many mothers who struggle. Whether they plan to breastfeed for six months or two years, they often need our help to get past the first few days and weeks. If they don't receive support in a timely manner they may conclude that they have no other option but to abandon

breastfeeding. You may encounter these women and their babies in the emergency room, office or clinic. Knowing how to recognize and respond to early breastfeeding problems is our collective responsibility.

Common reasons that women give for discontinuing breastfeeding include nipple pain, perceived milk insufficiency and lack of support. These factors and their cures are addressed in the mini-primer below. My hope is that the primer will help you tend to the mothers and babies in your practice who are at risk for unnecessary cessation of breastfeeding.

As health care providers who are mindful of preventive medicine and the Healthy People 2020 goals, we strive to teach our at-risk patients about the benefits of portion control, good nutrition, and exercise. We know that it is important to advocate for the removal of poor-quality foods from school lunches, for the use of car seats and bicycle helmets, and for early intervention in mental illness or abuse.

We should add basic breastfeeding education and support to these advocacy efforts. Families who are inspired to make one positive decision or change for their children are often compelled to make another. By the same token, families who begin infant care with breastmilk may be more inclined to offer nutritious food to their toddlers and school-age children. As effective promoters and supporters of long-term breastfeeding, we can guide them on the path to health. ◇

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A First Responder's Primer for Early Breastfeeding Problems

Early and often

Putting babies to breast in the first hour after birth is linked to better and longer breastfeeding. Letting babies nurse as often as they desire will help mom make the right amount of milk.

Keeping mom and baby together

Mothers and babies need each other. Rooming in, baby wearing and sleeping in close proximity all help babies have the regular access they need to feed well and grow. Mom's milk production is also in better sync when her baby is nearby.

Belly to belly

The goal is to position the baby so that its head and body are in line with the mother's body. By approaching the breast directly rather than with its head turned towards the side, the baby is better able to get a good grasp of the areola for optimal milk transfer. This is easier to do if the baby is "skin to skin" or minimally wrapped so that mother and baby's clothing do not create additional distance between the breast and mouth. Go ahead and gently rotate the baby so that it is facing the nipple. Easy and important!

A good latch

Babies are born to suck. With a proper latch at the breast, they can extract the right amount of milk, and mother should not feel any pain. The nipple should be deep in the mouth with the lips flanged out around the areola. You should be able to see—and may even hear—rhythmic sucking and swallowing.

Squished nose breathing is fine

Resist the urge to create an unnecessary "breathing space" between mother's breast and baby's nose. Gently dissuade the mother from doing the same. Babies can breathe just fine with their faces pressed into the breast, and this up-close connection helps them effectively remove milk. Using a finger to compress the breast will cause the baby's mouth to slip to the tip of the nipple. This is painful for the mother and leads to an underfed, fussy baby. Complaints of nipple pain and unsatisfied babies are common reasons for premature cessation of breastfeeding.

Sleeping like a baby

Mothers who know what is normal about infant sleep patterns (irregular and sometimes short!) are better able to accept that frequent night-time waking and feeding is okay. Help them to understand that the term infant's body clock doesn't mature until 6–12 months. Therefore mothers should sleep when the baby sleeps (especially during the day or any long stretch), as this may save her sanity. Baby's daytime naps are **not** a time to catch up on household chores. Mom should give those jobs to anyone who is willing.

Time to nurse

Babies have personalities, and—just like us—some are rapid gobblers, while others slowly graze. It is recommended that they nurse at both breasts each session to help stimulate milk production. Over time the baby will teach the mother how long this is going to take.

Once mom and baby have mastered the basics, 15–20 minutes per breast is typical. It is not uncommon for one nursing session to end just as the next one begins; this is called "cluster feeding." The good news is that these back-to-back sessions just might lead to a lovely, long nap. You can usually recommend that the mother "follow the leader" (her baby) when it comes to length and frequency of feeds.

Frequency

Breastfeeding infants should nurse 8–12 times in 24 hours. This isn't a schedule—it's a guide. Every baby is unique. This nursing guide doesn't begin until after the first 24 hours. It is perfectly okay and normal for the term, well baby to have a peaceful, long sleep after birth and then wake up feeling hungry the next day.

Don't interrupt

Breastfeeding is a big job for a little brain, and babies need to focus. Extra noise and activity can be a distraction. Once mom and baby have finally achieved a functional latch, they shouldn't be interrupted.

Stop confusing the mother

Imagine how you would respond if everyone you encountered gave conflicting advice about the right way to do your new job. Add fatigue, pain and a dose of self-doubt, and it would be even more daunting. No wonder new mothers "turn to the bottle" when we offer incorrect or confusing advice. Collaborate with your lactation consultants and colleagues and make sure everyone has the same script.

Happy baby

Everyone wants the baby to be happy and healthy. Include the grandparents, aunties, friends and visitors when you are teaching. It takes a village, and good news spreads! Extol the virtues of breastfeeding, acknowledge the mother's labor of love, and praise the baby for being smart enough to know how to nurse!

Feeding the mother

Everyone wants to feed the baby—but that leads to missed sessions at the breast that can derail milk production in the early weeks. The best advice is to feed the mother instead. The people in her support system can do this by preparing meals, caring for her children, performing household chores, running errands and doing anything else she needs. This extra help will allow the mother to eat well and rest more, which will boost her milk production.

Compassion

Breast milk is more easily released when the mother is relaxed. Your kind words and gentle assistance go a long way with this patient.

Call the lactation consultant

If the tips and tricks above don't get the desired results, you can call the lactation consultant. Busy ER doctors, surgeons or anyone caring for a breastfeeding mother or baby should have the consultant's number at the ready. At Marin General Hospital, it's 415-925-7522.

For more information

Visit the La Leche League website at www.llli.org.

The Role of Acupuncture in Modern Medical Practice

Martin L. Rossman, MD, Dipl Ac

When I first introduced acupuncture into my medical practice in 1972, there were no American training programs in Chinese medicine, no licensure, and very few practitioners. Now there are nearly 160 acupuncturists in Marin County (but only a few physician acupuncturists), licensure programs in almost every state, and 50 acupuncture colleges throughout the United States granting both master's and doctoral degrees. Nationwide, approximately 12,000 acupuncturists, including an estimated 2,000 to 3,000 physician acupuncturists, are currently in practice.

According to the 2007 National Health Interview Survey, an estimated 3.2 million Americans had used acupuncture in the previous year. While pain is by far the most common complaint treated with acupuncture,[1,2] the procedure is also quite useful in clinical conditions as diverse as allergic rhinitis, asthma, COPD, carpal tunnel syndrome, dysmenorrhea, tendinitis, bursitis, and nausea from anesthesia, pregnancy or chemotherapy.[3–11]

In the early 1970s, as a young physician with many chronic-illness patients in my practice, I became frustrated with the limitations of my treatment options. In late 1971 our medical staff meeting featured a videotape made by the first AMA Blue Ribbon delegation to China after diplomatic relations were restored earlier that year. The video showed a patient having a pulmonary lobectomy with only a few subcutaneous acupuncture needles for anesthesia in his arms and legs. While the surgeon transected the patient's ribs and lifted the diseased pulmonary segment out of his chest, the patient, fully conscious, was sipping tea and talking with the attending nurses. The head of the AMA delegation, Dr. Samuel Rosen, an eminent professor of surgery at Columbia, commented, "We saw a hundred such operations and cannot explain what we saw. We think that this phenomenon requires immediate and thorough investigation."

Dr. Rossman practices integrative medicine and medical acupuncture in Greenbrae.

I soon volunteered to help with the first major U.S. study of acupuncture for intractable-pain patients and saw with my own eyes that patients who had failed spinal tractotomies, multiple nerve blocks and intensive polypharmacy at the Mayo Clinic, University of Michigan and Case Western Reserve could often be helped with a course of 12–15 acupuncture treatments. At the end of three years, the authors reported significant help for 40–45% of them.[12]

In the intervening 40 years, both clinical and basic science research have helped us better understand how acupuncture works and the roles that acupuncture can play in medical practice. Humoral and neural mechanisms have been identified, and electromagnetic factors are now being studied. It has been well demonstrated that acupuncture analgesia is at least partially mediated by endorphins and enkephalins in the limbic system, midbrain and spinal cord. Research in China and Europe has also revealed that other neuroactive peptides—including serotonin, substance P and CCK—are involved with responses to acupuncture.[13,14]

While humoral mediators are the best-researched mechanisms, CNS and ANS mechanisms are also clearly involved. Melzack and Wall's gate theory of pain is thought to explain part of acupuncture's pain relief, whereby the non-painful stimulation of acupuncture stimulates fast myelinated A-delta fibers that inhibit the transmission of the larger, slower C-fiber signal in the ascending pain pathways of the spinal cord.[15] We now have over 750 fMRI studies showing that acupuncture alters pain transmission pathways in the cortex, thalamus and cingulate gyri; inhibits the recruitment of brain areas that amplify pain signals; and suppresses limbic and midbrain nuclei known to be involved with pain perception and transmission.[16]

Clinical acupuncture research is a problematic area because the "gold standard" double-blind, placebo-controlled clinical trial that works well for pharmaceuticals does not work well for procedural interventions like acupuncture. It is difficult if not impossible to design a true placebo control for acu-

puncture, and it is impossible to double-blind acupuncture studies. Patients and practitioners know whether or not points are being stimulated in spite of attempts to design a sham stimulation. To complicate matters, stimulation of non-acupuncture points on the skin has been shown to have significant analgesic effects.[17] This makes it difficult to demonstrate significant differences between verum and sham acupuncture, especially with the small sample sizes and inadequate duration typical of most Western acupuncture studies.

In spite of these research difficulties, an expert panel of 17 evaluators from academic medical institutions around the country convened by the National Institutes of Health in 1997 concluded that there was good quality evidence for acupuncture's effectiveness in the many conditions mentioned earlier in this article.[3] They acknowledged the remarkable safety record of acupuncture and issued a call for more research in two dozen other conditions where the evidence indicated that acupuncture was likely to be effective.

As clinicians with patients in pain, or suffering from chronic illness, when should we think about referring for acupuncture? I think the bottom line is this: If a patient has a persistent pain problem unresponsive to relatively simple short-term and safe pharmacotherapy and doesn't require immediate surgical intervention, it makes sense to refer them for a brief trial of acupuncture. It will help many of them and won't harm those that it doesn't help. If you refer a patient, have them return to you after six treatments for a re-evaluation. If they show improvement with frequency, intensity and tolerability of symptoms, or have been able to reduce analgesic or other medications, recommend that they have another six treatments and then follow up again.

If someone isn't showing definite signs of improvement by six treatments, they have given acupuncture a fair trial, and it is appropriate to move on to another form of treatment that may help them more. If they are improving during the trial period, they usually will require a total of 9–15 acupuncture treatments over 3–4 months. Some patients will obtain long-lasting results, while others will require maintenance treatments at varying intervals, depending on the chronicity of their condition.

The nature of the condition is not the sole determining factor in whether acupuncture can help a patient. Each patient has an innate responsiveness that varies from non- to exquisitely responsive. In a highly responsive patient, we can often help in conditions that are not usually treated with acupuncture; but in a low-response patient, we may not be able to help with conditions that usually have high success rates. The six-session clinical trial will indicate whether or not pursuing treatment makes sense in any individual patient.

Acupuncture responsiveness is a biological trait. Sprague Dawley rats nonresponsive to acupuncture can be converted to responsive animals by administering cholecystokinin, an endorphin agonist.[18]

As with any other professional referral, a physician should get to know reliable, accountable sources for acupuncture. Physicians and patients alike are often more comfortable with a physician acupuncturist, especially when they have chronic, serious or complicated medical conditions. A physician acupuncturist is likely to better understand medical terms, conditions and pharmacological treatment, and may also be better able to communicate with referring physicians. Visits to physician acupuncturists may be reimbursable by insurance, especially if the treatments are part of a program encouraging patients to eat well, exercise within capacity and manage stress more effectively. My patients with PPO insurance average about 60% reimbursement on their charges, with some receiving 40% and others as much as 90%.

Wherever you refer, there is some measure of quality assurance by selecting board certified diplomates of the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), which has set nationally accepted criteria for education, experience and ethical behavior of acupuncturists. The American Academy of Medical Acupuncture is another reliable source for selecting quality medical practitioners.

One of the important advantages of acupuncture as a therapy is its remarkable record of safety. In careful hands, using sterile, disposable needles (and there is NO reason to refer to an acupuncturist who does not use disposable needles), the risk is virtually nil. Reported adverse effects are extremely rare and predominantly consist of local infections around needle sites or temporary exacerbations of symptoms that rarely last over 24 hours and are often followed by improvement. While more serious complications (including pneumothorax and transmission of infectious disease) have been reported, these are truly rare. English and Norwegian studies indicate that an acupuncturist might cause one serious event in 100 years of full-time clinical practice, a safety margin that far exceeds the risk of prescribing analgesic medications or other interventional procedures.[19]

Acupuncture & Weight Loss

Research on acupuncture in weight control is mixed and confusing. On the one hand, acupuncture has been shown to alter levels of leptin, ghrelin, insulin and CCK, and helped increase weight loss when combined with low-calorie diet and exercise. Other studies have not shown the weight-loss effect. In my experience, acupuncture is a useful adjunct in the responsive patient (see main article). Placement of small metal pellets in appetite suppression points can help in early stages of weight loss. Ear stapling can cause infections and has never been demonstrated to be more effective than the non-penetrating pellets.

When acupuncture is more integrated into our system of medicine, it will be used much earlier in the evolution of pain and other disease syndromes, and we will have even better success than we do now. Patients should have a trial of acupuncture somewhere between taking intermittent and regular doses of analgesics or anti-inflammatories, and certainly before embarking on long-term use of narcotic analgesics or invasive procedures. Those we cannot help with this often effective and safe intervention can then consider riskier, more expensive and more invasive alternatives. ◇

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Hearing Loss in Children

Peter Marincovich, PhD, CCC-A

The social stress that children with hearing loss go through at school, at home and with their peers can powerfully hinder their confidence and social development. While most people living with hearing loss are adults who have developed worsening symptoms over time, over 15% of children in the United States have moderate to severe hearing loss in one or both ears. Additionally, early-onset deafness can be passed on genetically, and about 33 babies are born with profound deafness each day in the U.S.[1]

Before the 1990s, it was not uncommon for children's hearing problems to go unnoticed until the second or third years of their lives.[2] Around this age, children exhibit observable signs of a hearing deficit, such as slow speech development and failure to respond to loud noises. Concerned parents, having no indicator of their children's hearing deficits until this point, would only then take their children to see a specialist for diagnostic hearing tests. As we now know, it is extremely important to identify hearing problems as early as possible in the critical period for language development, which runs from birth through early adolescence.

The main effects of child hearing loss include delay in the development of speech and language skills, reduced academic achievement, social isolation, poor self-esteem, and fewer vocational options later in life.[3] Intervention before six months of age, research shows, leads to significantly better speech and reading comprehension than in children who receive attention after this critical period.[2] Failure to first identify child hearing problems until two to three years of age can result in irreversible impairments in speech, language and cognitive abilities, leaving the child with a significant disadvantage among his or her peers.

Without early intervention, the detrimental effects of hearing loss accumulate over time. To properly identify hearing loss in newborns, physicians and audiologists have implemented screening protocols within hospitals and birthing centers. When a newborn fails the screening test(s), the report goes to the child's primary care physician, who then refers the child to an audiologist for complete testing to determine the degree of hearing loss.

Treating hearing loss is an ongoing process that requires regular visits with an audiologist and other professionals. Regardless of the patient's age or degree of hearing loss, audiologists emphasize all aspects of care. Amplification is prescribed and adapted to the child as the child adapts to the amplification. Audiologists provide detailed reports for primary care physicians, speech pathologists, and other professionals who may be involved in a child's care, and they help ensure that each decision made during the child's treatment is based on a compilation of expert information.

Ideally, by the age of three, Individualized Education Programs are developed to organize care for children with hearing problems. The IEPs are designed to maximize each child's success despite his or her hearing and learning disadvantage. The audiologist's overall goal is to help hearing-impaired children stay connected with the world, and to minimize the social problems and sense of detachment that arise from loss of hearing.

Educating family members, especially parents, about the potential causes and signs of hearing loss can go a long way to prevent hearing loss in children. It is difficult for people of all ages suffering from hearing loss to even realize that they have a hearing deficit; for infants and toddlers who don't yet

Dr. Marincovich owns Audiology Associates, which has offices in Novato, Mill Valley, Santa Rosa and Mendocino.

have the language skills to grasp the concept of hearing loss, observant family members play an essential role in early identification.

One common cause of hearing loss in children is ear infection. According to estimates, three out of four children will have at least one ear infection before they reach three years of age.[4] In rare instances, ear infections that do not receive treatment can result in irreversible loss of hearing. Since ear infection often occurs before children can verbally express their ear pain, audiologists and other providers can help by reviewing with parents the various signs that might indicate an ear infection. These signs include tugging or pulling at the ear, fussiness, difficulty sleeping, fever, lack of balance, and failure to respond to sound.

A frequent complaint from parents raising children with hearing loss is that their kids often refuse to wear hearing aids. The benefits of wearing hearing aids far outweigh the embarrassment, but this point is never easy to get across to an upset child. In my experience, discussing in detail with children and their parents the importance of wearing hearing aids every day helps lessen the social anxiety that these children might feel. Parents are also appreciative when I prepare them for arguments that inevitably arise between themselves and their children over wearing hearing aids.

Tests for diagnosing hearing loss in children include Otoacoustic Emissions (OAE), Auditory Brainstem Response (ABR), Visual Reinforcement Audiometry (VRA), Behavioral Observation Assessment (BOA) and Conditioned Operant Response (COR). While newborns may have one or several of these tests performed at their initial health screening, the American Academy of Pediatrics recommends that all infants and children receive hearing tests periodically after their initial screening.[5]

Pediatricians should be aware of referral sources available in their regions for hearing-impaired children. Children suspected of having a hearing impairment can definitely benefit from seeing an audiologist in the diagnostic stage of their treatment. Audiologists are trained in interpreting test results, as well as determining the next step in treatment upon analyzing those results. Audiologists are also usually acquainted with several otolaryngologists and speech pathologists, serving as a qualified intermediary for referrals to experts in parallel fields.

Child aural rehabilitation (or, in many cases, "habilitation") is an ongoing process that may continue throughout life. Immediate and long-term goals of aural rehabilitation include training the auditory system to perceive sound, gaining understanding of body language and visual cues, improving speech, developing language, learning to manage hearing aids and assistive listening devices (ALDs), and ultimately improving communication.

Modern hearing aids provide the most beneficial solution to child (and adult) hearing loss in the majority of cases. While some children with hearing loss are able to develop viable oral communication skills with conventional hearing aids, many require cochlear implants to significantly improve hearing. The treatment depends on the degree and type of hearing loss.

Early detection of hearing loss and early use of amplification with hearing aids, cochlear implants and/or ALDs has been shown to make a dramatic, positive difference in the language acquisition abilities of a child with hearing loss.[6] The auditory system requires exposure to sound in order to develop audible communications skills. Wearing hearing devices as often and as early as possible is of the utmost importance. An infant as young as four weeks old can be fitted with today's amplification technologies, and the effectiveness of these devices improves the sooner a child with hearing loss achieves greater access to sound.

Working with children dealing with hearing loss is wonderfully rewarding. In all my years of experience helping people overcome their hearing problems, nothing is more gratifying than watching a child's face light up when he or she first experiences clear sound again. By carefully coordinating care between physicians, parents, teachers and others close to children with hearing loss, we can mitigate the disadvantages of hearing problems early on, when treatment is most effective. ◇

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Seeing What Isn't There

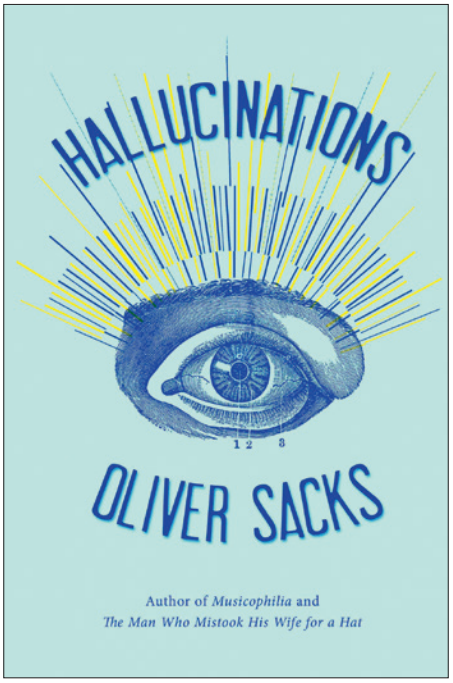
Irina deFischer, MD

Hallucinations, by Oliver Sacks, Knopf, 352 pages.

If you've ever wondered if a patient who reports vivid hallucinations but seems otherwise of sound mind should be referred to a psychiatrist, this is the book for you. Author Oliver Sacks—whose many other books include *Awakenings, The Man Who Mistook His Wife for a Hat,* and *A Leg to Stand On*—is a professor of neurology at NYU. His latest book, *Hallucinations,* is a catalog of every imaginable type of hallucination, other than those associated with frank psychosis. He draws on historical accounts as well as his own experiences and those of his patients and correspondents.

Hallucinations is organized into 15 chapters, forming a natural history or anthology of hallucinations, based primarily on first-hand accounts. The first chapter begins with Charles Bonnet syndrome, named for the 18th century Swiss naturalist who first described the condition. The syndrome is characterized by elaborate visual hallucinations in people who have lost their eyesight. Sacks goes on to describe hallucinations induced by other forms of sensory deprivation, as well as a variety of auditory hallucinations, such as voices and music.

Dr. deFischer, a family physician at Kaiser Petaluma, is president of MMS.



Another chapter focuses on the illusions of Parkinsonism, in which hallucinations can stem from both the disease and the medications used to treat it. One of the more remarkable chapters is the one on altered states, in which Sacks begins with a history of humans' use of hallucinogenic plants to transcend their day-to-day lives, whether in search of a religious experience or for pleasure and euphoria. Sacks goes on to recount the discovery of LSD and then proceeds to describe his own experiences with a staggering array of hallucinogens, stimulants and sedatives while a neurology resident at UCLA in the 1960s. Apparently he restricted their use to weekends and was able to continue putting in 60-80 hour workweeks. After completing his residency, he moved to New York for a research fellowship, where he treated his insomnia with large doses of chloral hydrate, then experienced a full-blown delirium when his supply was exhausted. One summer in London at his parents' home, he went so far as to inject morphine out of boredom, but he decided that once was enough.

In other chapters, Sacks describes visual phenomena associated with migraines and hallucinations of epilepsy, referred to by Hippocrates as the "sacred disease," or disorder of divine inspiration. In one example, Sacks attributes Joan of Arc's powerful visions to the ecstatic aura of temporal lobe epilepsy. Russian writer Fyodor Dostoevsky also experienced ecstatic seizures that produced feelings of ecstasy or transcendent joy, as described in several of his novels.

Sacks attributes many examples of divine and artistic inspiration to a variety of hallucinations. I do not entirely agree with his reductionist approach, but I found his book interesting and informative, although it was not an easy read. I recommend taking it slowly, a chapter or two at a time. Then you can reassure your patients they're not necessarily crazy if they're seeing or hearing things that aren't there! ◇

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Health Reform Heats Up

James Noonan

President Obama signing the ACA in 2010.

More than three years have passed since the Affordable Care Act (ACA) was signed into law, setting into motion some of the most dynamic and volatile years the nation's healthcare industry has ever seen.

Since its inception, the ACA has been a subject of controversy, inspiring hotly contested debates across the entire nation. For some, this dramatic overhaul of the country's healthcare system represents our national leaders finally making good on the long-overdue promise of "healthcare for all." Others claim that the law is a clear overreach of federal authority that threatens to overburden an already fragile economy.

Although the law remains controversial, the United States Supreme Court has ruled that it is constitutional, and active steps are being taken to move forward at the federal and state level. The vast majority of activity is yet to come. With many of the provisions set to take effect next January, state officials across the nation are scrambling to make sure they're ready to implement the law's sweeping changes.

The road has already been somewhat rocky. Throughout the implementation process, the U.S. Department of Health and Human Services has been narrowly meeting its own deadlines, oftentimes leaving states waiting for federal guidance that could dramatically alter their own implementation plans. With several major deadlines coming in the next few months, many observers expect this problem to only get worse.

Adding to the headache for the federal government is the mixed support that the ACA has received from the states. To date, only 17 states and the District of Columbia have elected to develop their own state-run "health insurance exchange" (also called "health benefit exchange"), an online marketplace where consumers can purchase subsidized coverage. An additional seven states will form state-federal partnerships to operate their marketplaces, while the remaining 26 states have declined to participate, meaning the federal government will be responsible for operating exchanges in those areas.

The next major milestone toward full implementation of the ACA is set to take place on Oct. 1, when the health insurance exchanges are set to begin their pre-enrollment. In the first years following these marketplaces going live, more than 32 million currently uninsured Americans are expected to gain coverage, either through an exchange plan or the ACA's massive expansion of the Medicaid program. Some analysts expect as many as 5 million of these newly insured patients to come from California.

On Jan. 1, 2014—three months after pre-enrollment begins—the exchanges are set to go live, meaning that millions of Americans will, for the first time, be able to purchase coverage using the federal subsidies promised in the ACA.

In order to navigate this massive undertaking, states will need to decide which plans will be offered through their exchanges and construct the actual online marketplaces through which consumers will purchase coverage. They will also need to implement major public outreach campaigns to ensure that these citizens—many of whom have never had the benefit of "open enrollment" or a similar purchasing period—understand how and where they can sign up for coverage under the reform law.

These tasks are daunting on their own, but with a deadline looming only months away, skeptics could be forgiven for questioning whether completing them is even possible.

Mr. Noonan is a staff writer for the California Medical Association.

Despite the uncertainty swirling around the ACA's implementation, California looks to be on track to meet the coming deadlines. In the days following the ACA's passage, California was the first state to establish a health benefit exchange (Utah and Massachusetts were operating their own versions of an exchange before the ACA was signed into law) and has been working toward implementation ever since. That exchange, named Covered California, has already launched its online consumer marketplace, www.coveredca.com, and is one of 25 states that have gained conditional approval from the federal government to operate its own insurance marketplace.

Unfortunately several recent decisions by the exchange board have placed California's physician community on its heels. The California Medical Association (CMA) has been an active participant in stakeholder hearings and is working to ensure that the interests of physicians and their patients are taken into consideration as the exchange prepares to open for business.

Several issues of concern arose when the board was working to finalize the benefit standards that interested payors will be required to meet in order to have their products considered for the Qualified Health Plan (QHP) designation. One major concern for physicians is how the exchange plans to deal with monitoring and ensuring network adequacy among QHPs.

Throughout the benefit design conversation, exchange staff continued to favor the existing method of network monitoring, which calls for the Department of Managed Health Care (DMHC) and Department of Insurance (DOI) to be responsible for ensuring that plans offered to consumers have enough participating providers. In other words, the status quo. Several stakeholders, including CMA, have noted that those two entities are currently unable to ensure adequate networks among existing plans and would likely be overwhelmed by the added task of monitoring additional exchange products. While CMA asked that the exchange take an active role in monitoring networks beginning in 2014, the DMHC/DOI method remained in the final benefit standards adopted by Covered California's board of directors, meaning it could become the norm once the state's marketplace goes live.

CMA also voiced concern over the exchange's handling of the "grace period" provision included in the ACA. Under current California law, patients who are delinquent on their premiums are allowed a full 90 days to settle up before their policy is terminated for nonpayment. However, under the ACA's grace period provisions, exchange plans will be allowed to suspend payment for services rendered if an enrollee is more than one month delinquent. If the patient fails to settle up within the three-month grace period, the plan can then terminate coverage for nonpayment and deny all pending claims for services. In this scenario, physicians could potentially be on the hook for 60 days worth of services with no avenue for recourse.

CMA has repeatedly asked Covered California's board to reconcile the state and federal policies, but to date an adequate fix has not been presented.

Given the exchange's accelerated timeline, as well as the exchange board's tendency to revisit issues that were previously thought to be decided, it remains possible that both of these matters, along with others that have caused concern to physicians, could see some sort of resolution before 2014.

To be sure, the next few months will be some of the most important and tumultuous times the medical community has faced in recent memory, but as a CMA member you have the comfort of knowing that your interests are being advocated for in front of all the key players driving the nation's reform efforts. ◇

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Kentfield Rehabilitation & Specialty Hospital

Curtis Roebken, MD

Remodeled patient room at Kentfield Rehab.

Note: *Each issue of* Marin Medicine *includes a self-reported update from one local hospital or clinic, on a rotating basis.*

Kentfield Rehabilitation & Specialty Hospital is excited to announce the completion of the first phase of its renovation begun last summer. On April 15, a new lobby, a conference room and an admissions office were opened, along with newly remodeled patient rooms. Patients needing assisted ventilation, dialysis treatment for life-threatening infections and skilled services for serious brain injuries are now being supported with new technologies.

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Kentfield Hospital, under the direction of CEO Ann Gors and the ownership of Vibra Healthcare, realizes the importance of long-term acute care hospitals (LTACHs) in the care continuum. As the Affordable Care Act begins implementation across the nation, the need for cooperation and coordination between varying levels of care is essential. Hospitals, home care agencies, skilled nursing facilities, physician groups and health plans must all partner in the provision of care. As we celebrate the renovations at Kentfield Hospital, we embrace the opportunity to improve patient care. ◇

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Dr. Roebken, a Kentfield internist, is chief of staff at Kentfield Hospital.

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LETTER TO THE EDITOR

A 53-YEAR-OLD breast cancer patient sat in my office last week looking at me nervously. She had just had a lumpectomy for a Stage I cancer in her right breast.

"I'm just not sure whether I want to risk radiation," she said. "I don't want to be having heart problems because of this 20 years from now."

She is one of the millions of women left alarmed and confused about their breast cancer treatment choices because of a recent widely reported study that looked at 2,168 women who had radiotherapy for breast cancer between 1958 and 2001 (*New England Journal of Medicine*, March 14). The data showed that a 50-year-old woman with no cardiovascular risk factors has a 1.9% chance of dying of heart disease before she turns 80 without radiation therapy; but it rises to between 2.4% and 3.4% if she has radiation treatment, depending on how much radiation hits the heart.

Since that study was published, I've talked with patients who suddenly are considering forgoing radiation after a lumpectomy, or having a mastectomy instead of lumpectomy, despite having only a small, early stage tumor. I've also talked with healthy patients who have undergone recent, successful treatment, and now are questioning their choice to have radiation therapy.

Their fear is understandable, but misguided—and even dangerous.

The study analyzed data from 1958—practically the Stone Age of radiation therapy—through 2001, more than a decade ago. Even at the end point, radiation doses commonly used far exceeded the norm today, and heart-sparing therapy techniques were not used in the study. To extrapolate the risks found in this study to today's treatment protocols is an apples-to-oranges comparison that needlessly frightens today's breast cancer patients. Further, it may lead many women to make decisions that increase their risk of dying of breast cancer significantly, while doing little, if anything, to diminish their risk of dying of heart disease.

The lead investigator even noted some of the study's limitations, saying, "[I]n order to have a long follow-up, we mostly included women who were treated more than 10 years ago. This means that we do not know how today's treatments are affecting women."

That comment should have been highlighted in the news coverage, along with these other important facts:

- With breast-conserving surgery alone (without radiation) women have twice the risk of recurrence of their breast cancer within 10 years.
- By decreasing the risk of recurrence in the breast, radiation saves lives. For every 100 patients with early breast cancer who decide not to have radiation therapy, three will die needlessly from this cancer.
- Patients with tumors in their right breasts have almost nothing to worry about, because their hearts get little if any radiation exposure.

Patients need to be told that today's better equipment and better techniques allow radiation therapy to be equally effective with far lower heart doses than almost any of the patients in the recently published study experienced. The use of heart-sparing radiation techniques, which are being adopted by more and more cancer centers every year, further reduce this risk. In fact, if this study were repeated starting with women being treated today using heart-sparing techniques, I'm confident the cardiac risk would be negligible.

My breast cancer patients face daunting choices, and they are right to consider carefully; but it would be wrong for them to base their decisions on out-of-date information. As even the study's author concluded, "For now, doctors can tell their patients that radiotherapy is a very important treatment and it should be used. However, they should try to lower the dose of radiation to the heart as much as possible."

—Francine Halberg, MD

Dr. Halberg is a radiation oncologist at the Marin Cancer Institute.

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A staff psychiatrist at Sonoma Developmental Center participates in the multidisciplinary team process for the management of individuals with intellectual disabilities. Sonoma Developmental Center is operated by the State of California, Department of Developmental Services, and provides long-term residential services for individuals with intellectual disabilities. The psychiatrist performs psychiatric evaluations, participates in the multidisciplinary team meetings and provides recommendations to the primary care physicians in the psychiatric medication management of complex behavioral problems. The psychiatrist is also available via email and pager for consultation with primary care physicians for urgent clinical issues.

SALARY RANGE:
$18,146–$22,377 per month

Applications may be downloaded from the California Department of Human Resources website at **www.calhr.ca.gov.** Applications MUST be filed in person or by mail with:

Sonoma Developmental Ctr.
Human Resources Exam Dept.
15000 Arnold Dr.
PO Box 1493
Eldridge, CA 95431

For more details, call Dr. Michael Wymore at 707-938-6566.

The Profession of Medicine Needs AMA

Peter Bretan Jr., MD, FACS

While less than 25% of the nation's physicians are members of the American Medical Association, the AMA has been and continues to be the largest and most accepted voice for the profession of medicine. We physicians tend to spend our time and attention with our own specialty societies, but only AMA represents our entire profession.

With the Affordable Care Act in full swing, including the planned expansion of coverage to more than 32 million previously uninsured patients nationwide, our state and national legislators are continually asking where AMA and the California Medical Association stand on these issues. Whether or not you agree with the many provisions of the ACA, it is now the law of the land and will affect us all.

The house of medicine has one voice nationwide through the AMA, and every legislator knows that. In their eyes, none of the specialty groups speak in a manner that gets traction with the White House or Congress. AMA gives us the best chance of getting bills modified to be more palatable for all of us and our patients.

AMA members laboriously seek consensus via the AMA House of Delegates twice a year. These meetings are an amazing process that includes many minority voices, along with thorough debate, dissent and finally consensus. Leaders are chosen by election, and the process is fair, transparent, durable, sustainable and—most important—intensely democratic.

Dr. Bretan, a Novato urologist, has been the CMA District X representative to AMA since 2003.

Although California is the most populous state, CMA needs many more of our physicians to join AMA so that we can adequately represent our patients and profession in this formidable process. The more AMA members, the more delegates and the better our ability to move CMA policies nationally. States are allocated one delegate per 1,000 AMA members. With this formula, Californian has only 22 AMA delegates; almost identical to the delegation size of the Texas Medical Society. We can do better … much better.

AMA legal successes are legend. In one famous case, Community Memorial Hospital in Ventura, Cal., tried to discard the bylaws of the medical staff. CMA asked the AMA legal team to assist, and they successfully overturned this egregious act against the hospital practice of medicine. Medical staff self-governance bylaws are now standardized by AMA and CMA and used throughout the country as the foundation for all medical staff bylaws. The ability of the Marin Healthcare District to regain their independence from Sutter Health is a direct consequence of these protections, and from the strong organization of local physicians at Marin General Hospital. What has arisen in Marin is a true partnership of physicians and hospital, benefiting all patients in this thriving medical community.

On the national scene, to name just one example, AMA has partnered with several state medical societies to help return almost half a billion dollars to physicians (including those in California) who were systematically underpaid for out-of-network services.

AMA believes there is a national imperative to improve the health of the nation. They also believe that physician leadership is critical to the successful evolution of healthcare in a patient-focused delivery system.

Now is the time to help support and grow AMA leadership. Join us in finding the common ground on which we can shape a healthcare system that delivers high-quality care with better health outcomes; that prepares physicians to meet the needs of a continuously evolving system; and that provides professional satisfaction and sustainable practices for all who choose healing as their life's work.

As physicians we must continue to enable a system that provides access to care for all, and we have a chance to accomplish this through efficient implementation of the Affordable Care Act. You can help us strengthen our professional voice in these endeavors by supporting not only CMA, but also AMA.

To join the American Medical Association, visit www.ama-assn.org. ◇

Email: bretanp@msn.com

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